NATIONAL HEALTH INSURANCE: SOLUTION OR MIRAGE

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THE ways of a nation, like the moods of a woman, often defy description. With little or no forewarning the 91st Congress introduced several bills involving the financing and operations of the medical-care industry. If even the most modest of these bills were passed, it would bring about significant changes.

Medical care for the nation at present costs about $65 billion, which makes it as an industry second only to construction. In terms of personnel it is the largest; it employs about 4 million workers. In terms of complexity it would be hard to match. The federal government spends more than $22 billion annually (including $12 billion via Social Security for Medicare and Medicaid). The vital center of the industry is comprised of the nonprofit general hospitals under voluntary sponsorship. Commercial and nonprofit insurance (Blue Cross and Blue Shield), primarily for services of hospitals and physicians for the care of inpatients, involve an expenditure of about another $12 billion annually. Expenditures for drugs and medical appliances, a private sector effort, total more than $8 billion. Dental care accounts for another $4 billion.

The core of the system of medical care consists of the 330,000 physicians; most of them—about 65%—are private practitioners who make their living on a fee-for-service basis. They remain one of the few strongholds of small-scale enterprise.

The following criticisms have been directed at the present health-care system, which sophisticates call the "nonsystem."

The system is skewed in favor of therapy rather than prevention; in favor of expensive hospital rather than less costly ambulatory services.

The insurance which people carry does not protect them against large medical bills; premiums are rising so rapidly that benefits may have to be reduced; and many of the poor and near-poor have no insurance.

Paying physiicans on a fee-for-service basis inflates costs, discourages people from seeking medical attention, and undermines the financial viability of Medicare and Medicaid.

There are no incentives at present to reward the purveyors of low-cost services; the present mechanisms of payment do not encourage the growth of group-practice units; and comprehensive prepayment plans —the preferred method of providing medical services—are growing very slowly.

There are serious shortages of health personnel, especially physicians; there is also serious maldistribution. Moreover, there is strong resistance to new patterns of utilization aimed at economizing in the use of high-cost personnel.

The poor and near-poor have limited access to medical care, with the result that our mortality and morbidity figures are unnecessarily high.

If these criticisms are accepted at face value—and most informed persons would agree with most if not all of them—then the surprise lies not in the spate of bills that have recently been introduced but rather in the fact that we delayed so long before seeking to reform our system of medical care, which is characterized by so many shortcomings.

In 1965 the Congress passed both Medicare and Medicaid, which sought to respond to two high priority deficiencies in our system: the need for medical-insurance coverage for persons over 65 and the need for access to service for the poor and near-poor below that age. But the price of securing the passage of Titles 18 and 19 of the Social Security Act came high: the leaders of organized medicine insisted on fee-for-service payment; the leaders of the hospital association insisted on cost reimbursement plus 2% override. The present momentum for additional reform was generated by the belated realization that the price of victory in 1965 was excessive as well as by the need to rationalize not only a part but the entire system.

Within the first three years after the passage of Medicare and Medicaid, Congress, the administration, and the states had to take the following actions to protect themselves from financial disaster resulting from runaway costs: at both federal and state levels the legislators cut back the criteria of eligibility for Medicaid and reduced the range of benefits; the tax levels and premiums for the two parts of Medicare

(hospitalization and services of physicians) had to be raised several times and amounted to increases of about 80 and 30% respectively; the 2% override for hospital reimbursement was eliminated; a freeze was placed on physicians' fees under the program. A recent study by the staff of the Senate finance committee pinpoints many other areas where remedial action is urgently required.

This brief recapitulation of our recent experience with legislative reform of our medical-care system should provide perspective on the quality of governmental planning, the interest groups that must be considered, and the shortfalls that occur between promises and fulfillment. With this background we may be in a better position to appraise the several proposals for National Health Insurance.

As the *Research and Statistics Note No. 12*, July 23, 1970, of the Social Security Administration entitled *National Health Insurance: A Comparison of Five Proposals* makes clear, the plans before Congress can be differentiated as follows: The Griffiths and the Reuther plans are based on the principle of social insurance, paid for in part by payroll taxes; they offer universal coverage and designate the federal government as the primary administrative agent.

The American Medical Association (AMA) and the Aetna Life Insurance Co. plans are predicated on private insurance, with voluntary coverage; they would provide governmental funds as supplements to private sources and would leave primary administration in the hands of the private insurance carriers.

Senator Jacob K. Javits' bill falls between. It provides for a universal federal program based on socially financed insurance but permits the "electing out" by persons who prefer private coverage.

The AMA proposal seeks to respond to the need to provide access for the poor and the near-poor for in- and out-of-hospital services by proposing to use governmental funds to cover all or part of the premium costs. In addition, it gives a sliding tax credit to all other purchasers of health insurance. As might have been anticipated, the AMA wants no changes in the ways in which the insurance carriers pay the providers of service. This means that they favor the continuance of fee-for-service and reimbursable costs for hospitals which, as noted above, have brought the Medicare and Medicaid programs into financial turmoil.

The Aetna proposal, although it looks to leadership by the private sector, is more innovative. It too seeks to insure the poor by govern-

mental financing, but it proposes to use state as well as federal sources. In addition it seeks the expansion of a "catastrophic medical insurance program" with a sliding scale according to family income, supplemented where necessary with federal and state revenues, and an improvement in employment-related insurance plans aimed at broader out-of-hospital benefits. But, like the AMA plan, this proposal seeks no changes in the way in which insurance carriers pay providers of services.

The AMA proposal is responsive to one of the six major shortcomings outlined above: the needs of the poor for access to the system; the Aetna plan to three of them: access for the poor; protection against catastrophic costs, and more reliance on lower-cost ambulatory service.

S. 4297, the handiwork of a technical committee headed by I. S. Falk who, interestingly, was a leading proponent of cumpulsory health insurance in the 1930's, seeks to be responsive to all of the six shortcomings identified above. Since the Griffiths bill differs only slightly from S. 4297 and since it now appears that organized labor will close ranks behind a single bill, I shall focus on this, the most detailed and explicit medical reform proposal based on social insurance now in the legislative hopper.

The Health Security Program, which is the formal title of S. 4297, has proposed a solution for each of the principal defects of the present system of medical care. Specifically, it provides strong incentives for comprehensive, professional group-practice units; it is thereby hoped to shift the concern of physicians from therapeutic to preventive medicine. To overcome the inadequacies of present-day insurance plans, it offers comprehensive benefits with only one major omission—dental services for adults—with limits on the length of stay in nursing homes (120 days of care per spell of illness); it limits covered mental health care to "active treatment"; and it provides prescription drugs for the treatment of long-term illness. The thrust is definitely in the direction of comprehensive care.

While the bill allows physicians to be remunerated on a fee-for service basis, clear preference is given to contractual arrangements that involve capitation, salary, or fees for sessions. Moreover, all purchasing arrangements are predicated on prebudgeting; if the sums allocated prove to be inadequate during the course of a year, the terms of contract with purveyors will be reduced accordingly.

To encourage the growth of comprehensive group practice, a 3%

bonus of total costs is allowed; further, in the allocation of expenditures, payments to such purveyors of services will take precedence over other arrangements, such as payments for physicians who elect to be reimbursed on a fee-for-service basis; and the federal board overseeing the entire system is directed to assist in the expansion of comprehensive care organizations through grants and loans.

There is a section of the bill (Part F) specifically directed to making funds available to alleviate shortages of facilities and personnel and to correct the maldistribution of personnel. For fiscal year 1973 the sum of $600 million is earmarked for these high-priority goals. The board is specifically instructed to assist organizations to expand sums in urban and rural areas to enable persons "who lack ready access to such services" to obtain them.

Since the bill provides coverage for all residents of the United States except members of the armed services and aliens admitted as permanent residents, the poor and near-poor will no longer be on the periphery of the health-care system but will be entitled to the same coverage as those who pay the maximum premium. Financing is estimated as follows: 7¾% of covered income, composed of 1.8% from employees earning up to $15,000; 2.8% of employers' total payrolls; and a contribution of about 3.1% of covered income from revenues of the federal government. Realizing that medical resources may not be available in areas in which the poor are concentrated, proponents of the bill have included special funds to speed the redistribution of physicians.

A word about the Javits bill, which seeks to establish a national health-insurance program by expanding the present Medicare program to include the general population. It provides, as we have noted earlier, that persons who purchase approved private insurance may elect exclusion. The benefits would be the same as under the present Medicare program with some additions phased in at a later date. Parenthetically, the present Medicare program covers only about 45% of the total costs of medical care of the older population!

Unlike S. 4297 the Javits bill relies on coinsurance and deductibles to discourage overuse and to help keep costs within tolerable limits but, like S. 4297, it gives important incentives to speed the growth of comprehensive-health-care organizations (who can keep two thirds of all savings) and it recognizes the need for new systems of paying for services in order to control costs and utilization.

There are radical differences among the three sets of proposals: S. 4297 promises the most; it deliberately aims to remove the financial barrier which prevents so many persons from seeking treatment; it uses financial and other incentives to speed the reorganization of American medicine; it addresses itself to the important matter of expanding and redistributing the supply of medical personnel. The AMA-Aetna plans seek to alter the existing system as little as possible while expanding access to it for the poor and improving the reach and quality of hospital-insurance policies. Javits is responsive to the need that the government do much more to provide coverage for the poor and near-poor and act to control costs and utilization. At the same time he contemplates a continuance of a strong interest for the private sector, both commercial insurance and such plans as Blue Cross and Blue Shield.

To develop a comprehensive plan requires considerable technical competence and, in this respect, S. 4297 must be given a good mark. It is at one and the same time broader in its reach and more specific with regard to structure and operations than the other proposals. It reflects careful deliberation and reveals considerable sophistication.

And yet on the crucial issue of costs it may be as unrealistic as the other plans before Congress. And they are unfeasible indeed. For instance, the AMA came up with a "final" estimate of a net cost of $8.3 billion, but the Social Security Administration calculated that a realistic figure would be $15.3 billion or 84% greater.

With regard to the cost of the Javits bill: the previously cited *Research and Statistics Note—No. 12* disclosed the cost as estimated by the chief actuary of the Social Security Administration at $22.7 billion for 1975. But in two different pages of the document (pp. 10 and 19) this printed figure is crossed out and $66.4 billion has been substituted in ink. This is the first time in my more-than-40 years of use of government documents that I have seen a correction of this magnitude made by hand!

The Griffiths bill carries an estimated cost of $35.8 billion, but in July 1970 its sponsor announced that she planned to reintroduce the bill next year with higher benefits and a higher tax, which I estimate will carry a price tag of an additional $5 billion.

The calculations of the cost of S. 4297 are much more uncertain. The Committee for National Health Insurance put a figure of $37 billion on the cost, but Undersecretary John G. Veneman of the

Department of Health, Education, and Welfare (HEW) in his Congressional testimony toward the end of September said that his department had recalculated the costs of the total package plus administrative costs and incentives and had arrived at a total of $77 billion! It all depends on one's assumptions. In introducing the bill in the Senate, Edward Kennedy said, "Overall, expenditures under the health security program will not create a new need for Federal health expenditures, layered on top of existing public and private expenditures for health care. Instead, the health security program is designed to achieve a rechanneling of expenditures already made, so that existing funds may be allocated more effectively."

Secretary Veneman's staff, apparently reflecting on recent experiences with Medicare and Medicaid, was unwilling to put much faith in potential savings from putative efficiencies and, further, he made a hefty allowance for continuing inflation of medical care prices that helps to explain much of the difference between $37 billion and $77 billion!

Only the Aetna proposal was advanced without an attached dollar figure.

While it might be considered a diversionary tactic to insist that the public and Congress be furnished firm estimates before making a decision about these several plans, it is not unreasonable to suggest that when calculated costs for a plan differ by 100 to 200% it behooves the legislature to probe deeply before acting. Even the rich federal government cannot be nonchalant about entering upon a new program which the optimists price at $40 billion *annually* below the estimate of those who view it askance.

The sloppiness with which the "figure game" is played is suggested by the following. In introducing S. 4297, Senator Kennedy pointed out that "the health security program we are preparing would have paid a total of $37 billion in personal health care services in the United States. Had the program been in existence in 1969 therefore it would have paid approximately 70 percent of the $53 billion in total health expenditures for the year or approximately twice the percentage that existing forms of public and private insurance now pay."

The senator did his arithmetic correctly: his estimated cost of $37 billion for S. 4297 is approximately 70% of $53 billion. Moreover, he is correct when he says that a system of National Health Insurance with a budget of $37 billion would have covered approximately 70% of all

personal health expenditures instead of the 35% now covered. (See p. 109. *The Benefit Structure of Private Health Insurance*, 1968, by Louis S. Reed and William Carr, Res. Rept. 32, Soc. Sec. Ad. HEW).

But the senator's arithmetic sheds no light on the critical issue of whether his estimated total would finance "the essential costs of good medical care for the years ahead."

Is there any way to handle the cost question in which experience rather than prejudice is the guide? As a first step, we might note Reed and Carr's conclusion in their comprehensive analysis: "If all of the population had comprehensive health insurance, such insurance would probably meet at least 90 percent of consumer expenditures for personal health services" (p. 109). If this is a valid criterion there is a potential shortfall in the estimates of S. 4297 of some $11 billion, or roughly 30%. The critical reader might say that this is a matter of opinion, not experience. Let us therefore look at Reed and Carr once again—this time for actual costs of so-called "comprehensive coverage." They refer to three preferred plans: Group Health Association in Washington under the Federal Employers Health Benefit program; Group Health Corporation of Puget Sound (special program for federal employees); and the Government-Wide Service Benefit Plan for Federal Employees. The authors present a range for family coverage from $733 (Puget Sound) to between $850 and $890 for the other two plans (pp. 110-11).

There is a strong presumption that the cost of $37 billion attached to S. 4297 is far off target since we have over 50 million families and 60 million households; since the cited costs of enrollment are for federal employees, a favorable risk group because of age, education, and occupation, and since we have no knowledge of the enrollees' expenditures for health outside the system.

Another way of looking at costs is to start with the $53 billion of expenditures for personal health-care services in 1969 and to add an amount for the poor and the near-poor who are not presently able to obtain access to even a minimally acceptable level of quantity and quality of health services. It is difficult to see how such an addition could add less than 20%, which would bring the total expenditures for personal health to more than $63 billion. If one adds an allowance for inflationary price increases for 1969 and 1970 the total would exceed $70 billion.

In offering his bill, Senator Kennedy remarked, "In essence, health security expenditures will replace the large amount of wasteful and

inefficient expenditures already being made by private citizens, by employers, by voluntary private agencies, and by Federal, State, and local governments. Only in this way can we begin to guarantee our citizens better value for their health dollar." The senator promised that the more efficient use of resources will:

> Pay for an expansion in health facilities and personnel.
>
> Provide more health benefits for the average citizen.
>
> Enable the poor and the near-poor to participate on approximately equal terms with middle and higher income groups in the use of health-care services.
>
> Improve the quality of the health-care services provided the American people.

All of these gains are to be financed not by the expenditures of new monies but by gains in the efficient disbursement of existing expenditures.

Let us look more carefully at the new approaches and mechanisms through which these great gains in efficiency are to be achieved. The first proposal is that comprehensive services for the entire population will mean that there will no longer be the encouragement that exists at present to physicians to recommend that their patients be hospitalized for diagnostic, therapeutic, and rehabilitative services which could just as easily be performed on an ambulatory basis. This in turn would reduce the cost precipitously by avoiding unnecessary hospitalization.

There can be no argument with the proposition that there is a costly bias in the present structure of insurance which makes many benefits contingent on the patient's hospitalization. This has been a long-term defect of both commercial and Blue Cross policies which helps to explain why the Aetna proposal has singled this arena out for experimentation aimed at shifting the balance from inpatient to outpatient care.

But it would be unwise to presume that this will be reflected in lower total expenditures for health care in the near future. It is hard to believe that a significant number of existing hospital beds will stand empty. If some part of the inpatient load is shifted and henceforth receives treatment on an outpatient basis the beds thus released would unquestionably be filled by persons who today are being turned away because of a shortage of beds or a shortage of money.

Even if, *mirabile dictu*, the beds were not filled with other patients

and were to stand empty, the net result would be a relatively small saving since a large part of the operating costs of running a hospital consists of overhead expenditures that cannot be cut back proportionately. While the proponents of the new health-security program are correct in believing that their proposal would discourage the unnecessary hospitalization now engendered by the limitation of many insurance benefits to inpatients, they cannot assume that the resultant savings could be "captured" and used to cover other costs of medical care. If there is one lesson extractable from the experience of countries in which medical costs are covered by social insurance or some similar type of governmental financing it is that hospitals are almost always full. In fact the major complaint in England, Sweden, and the communist countries of Eastern Europe is the extreme shortage of general hospital beds. When I was recently in Budapest I was impressed by the necessity of doubling up patients—not two to a room, but two to a bed!

A second strongly held conviction on the part of the proponents for national health insurance is that substantial economies will be achieved by shifting the fulcrum of the system from therapy for sick persons to protection of the well-being of healthy individuals. In short we are to follow the "Chinese" approach and pay the medical profession for keeping us well. Let us quickly grant that we are not doing as much as we should on the prevention front. Many children are not being immunized against smallpox, diphtheria, measles, poliomyelitis, German measles, or tetanus. If children live through these diseases, the sequelae often are permanent disabilities.

The crux of improved preventive medicine lies not in correcting these marginal defects but in reaching professional consensus about the value of multiphasic screening, annual physical examination, and communitywide specific diagnostic procedures for cervical cancer, tuberculosis, and other life-threatening diseases. It would be wrong for a layman to cast a vote in this complex arena where the experts differ. But this much should be noted: S. 4297, as well as the Griffiths and Javits bills, include annual physical examinations among their benefits. This will inexorably add to the costs of operating the health-care system in the short-run even if, as the proponents believe, significant savings in lowered mortality and morbidity are achieved in the long run. In England it is not unusual for a general practitioner to have a capitation list of 2,000 persons. An annual physical examination for

all adults, even if carried out with heavy reliance on technology and allied health manpower, could preempt a quarter to a third of a physician's annual working time—if the examination is to be more than perfunctory and include some counseling of the patient. There is no scintilla of evidence to indicate that an investment of this magnitude is warranted.

It is important to point out that as a nation we have failed to control the controllable aspects of mortality and morbidity—a failure that has little to do with the way in which our medical care system is organized and functions. A successful program of prevention would have to face up to the following challenges: how to reduce the mortality and morbidity resulting from overweight, smoking, alcohol and drug addiction, highway accidents, and suicide—to name only the major causes of preventable deaths and injuries. More than faith is required to see a reform in the medical care system as responsible to these challenges.

The keystone to the reformer's work in the remodeling of the system of medical care is the expansion of group-practice units, preferably the creation and expansion of group-practice units that provide comprehensive services through a prepayment plan. Presumably, arrangements for medical care based on prepayment would remove the distortions brought about when people must weigh the type of medical care they seek in terms of the insurance policies they hold or the fees they must pay. But, as the head of Kaiser-Permanente has recently written, prepayment is also not free of distortions. In Dr. Garfield's view, a prepayment system tends to commingle the groups who compete for the same resources: the sick, those who imagine they are sick, and the healthy.

In any case S. 4297, as well as the Griffiths and Javits bills, are written to encourage the growth of group-practice units. The sponsors assume that such units can provide more and better care at a lower unit and total cost. Conventional wisdom holds that, were it not for the opposition of organized medicine and the strength of the solo practitioners in its ranks, group practice would long since have become the dominant pattern in the practice of medicine. As early as 1932 the Commission on the Costs of Medical Care stressed the desirability of the rapid expansion of group practice units that offer comprehensive services.

Certainly organized medicine, through its control over state legisla-

tion that governs the practice of medicine, succeeded in slowing the growth of group practice. But that is history. For the last decade or two group-practice units of varying types have proliferated and, although the trend has been less steep than anticipated, the fault cannot be laid at the door of organized medicine.

But our concern relates more to economics than to history. Several of the bills now before Congress are predicated on the assumption that the rapid growth of group-practice units that offer comprehensive services presents the best prospect for expanding services while keeping costs down. In fact, these bills contemplate the use of federal funds in the form of incentives, grants, and loans to speed the growth of group practice of comprehensive medical care.

Interestingly, there is little firm evidence about the savings that accrue from group practice. Bailey, who has studied the matter in the San Francisco area, presents the tantalizing findings that there are no economies whatever in the utilization of the time of the physician; there are however, increases in the gross and net earnings of physicians that result from their use of more elaborate diagnostic and therapeutic practices that involve the use of allied health manpower.

In the absence of a firm measure of output—the number of patients correctly diagnosed and treated—little importance can attach to the fact that physicians associated in group practice have larger total billings and incomes. This is hardly a satisfactory proxy for better medical care. Klarman recently reviewed all of the empirical studies that deal with group practice and concluded that they were planned and executed in a manner that did not permit one to draw definitive conclusions about the results. Yet the medical reforms are unequivocally committed to the belief that the rapid growth of comprehensive group-practice units will result in better care at less cost.

Ever since the Magnuson Commission Report of 1951, all efforts to improve the established system of medical care have come face to face with past and prospective shortages of facilities and personnel, especially the latter. The bills now in Congress are not exceptions. In Senator Kennedy's presentation of S. 4297, he listed as the first of three causes of the present health crisis the "national shortage of health manpower and institutions." Moreover, in Part F, the bill provides "financial and other assistance in alleviating shortages and maldistribution of health personnel and facilities in order to increase the supply

of services." In addition to authorizing the federal board to subsidize the training of family physicians and specialists where it finds a critical shortage to exist, the bill stipulates that the board provide for the education and training of subprofessional or nonprofessional personnel "to assist in the providing of comprehensive health services" and for other activities such as health maintenance and liaison between the medical institutions and the residents of the area.

A few comments on this critically important sector of the bill. There has been a major transformation in health manpower both in the long and the short run. Early in the century there was one physician to two other health workers; today there is one physician to about 11 others.

The last two decades have seen an expansion of medical manpower at a rate three times faster than that of the labor force as a whole. And even the so-called shortage of physicians must be reappraised in light of the latest data, which point to a steadily improving trend in the ratio of physicians per population. Many persons in the higher as well as the lower income brackets resent the fact that they cannot get a physician to come to their homes when they are sick and that they are unable to discuss their conditions thoroughly with a physician even if they go to his office or a clinic, but it is highly questionable whether any prospective expansion in the supply of physicians would obviate these particular shortcomings.

Consequently the proposed legislation places considerable stress on expanding the pool of allied health manpower in the hope and expectation that this will provide a larger part of total medical services, thereby permitting the expansion of services while keeping costs within bounds. But, to repeat, this is the road that we have been traveling for the last 70 years, especially the last 20 years. This is not to say that we should not go further or faster in this direction. But there are a few caveats.

Malpractice suits are at an all-time high and give no promise of leveling off. Unless some form of reinsurance, possibly with governmental assistance, is developed, physicians will inevitably be forced to become ever more cautious in their practice. It is difficult to see how they can be asked to delegate more and more responsibility for the assessment and care of patients to allied health workers if they are vulnerable to malpractice suits growing out of possible errors of their assistants.

From recent surveys carried out by *Medical Economics*, it appears that one of the locations where more allied health manpower could be productively and profitably employed is in physicians' offices. But we know that one of the attractions of medicine as a career is the desire of many physicians to deal with patients on a face-to-face basis and to avoid administrative and managerial duties. The economist may be able to prove on paper that the practitioner can increase his net income if he has four assistants, but it does not follow that the physician who makes a good living with one assistant will be inclined to alter his practice to maximize his income.

The proponents of national health insurance have overlooked the distinct possibility that with government as the strategic party in financing the health-care system it may not be long before various allied health groups will develop the muscle to secure substantial salary increases. As a result many of the "calculated" economies which are expected to be derived through substitutability may evaporate. There is the additional threat, supported by Bailey's studies, that the presence of more allied health manpower may lead to additional procedures that will increase total costs without necessarily improving the quality of medical care. If the government pays the bill we can expect physicians to recommend another set of x rays or a few more tests in order to pin down the diagnosis.

But S. 4297 as well as the Griffiths and Javits bills take cognizance of the dangers of open-ended governmental financing and are determined not to repeat the horrendous miscalulations of costs that characterized the early years of Medicaid. They are geared to prebudgeting. That is, the contracting agencies that will provide the care will stipulate in advance the sums they will pay for the medical services a stipulated population is to receive. This applies to remuneration of all prime contractors, be they groups of physicians, hospitals, or other purveyors of services. In fact S. 4297 contemplates the possibility that during the course of a fiscal year the total sum available to the board may be depleted more rapidly than the planners had calculated. In that case the bill provides for the proportionate reduction in the rate of reimbursement that will be paid to physicians during the remainder of the year.

There is much to be said in favor of prebudgetary controls, especially in light of the runaway costs that have characterized both

Medicare and Medicaid, which have operated on usual, customary, or reasonable fees for physicians. But the effectiveness of stringent financial control is a paper solution, not a real one. Its effectiveness is predicated on a series of implicit assumptions, such as the inability of the physician to reduce the amount of time and effort he can make available to his patients or his inability to recapture his "lost income" through recourse to additional procedures.

The proponents of national health insurance expect that the reforms of the system outlined above will be viable and profitable. However, this will be true only if more patients are treated on an ambulatory than an inpatient basis; only if more attention to prevention will reduce morbidity; only if physicians will practice as members of groups, preferably offering comprehensive services; only if more use is made of allied health manpower and, finally, only if prebudgeting really works.

Grounds for skepticism remain. Government has difficulty in performing such simple services as keeping a city clean, educating children from low income homes, maintaining safety in the streets. Of the $20 billion of federal medical expenditures an estimated 20% is spent at the cutting edge to develop new knowledge and applications to raise the health of the American people. The poor need improved access to medical care but the public at large is interested in better health. It makes no sense to spend an additional huge sum—$25 to $40 billion—chasing a chimera. The poor will still be at the end of the queue and the health of the American people will not be appreciably improved.

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Addendum

Since the completion of this article in the autumn of 1970 new proposals have been formulated. The two of greatest importance are President Nixon's National Health Insurance Partnership and the Ameriplan of the American Hospital Association. They incorporate consumer cost-sharing through deductibles and coinsurance, catastrophic protection, and fluctuating consumer payments related to family income.

For reasons of space, this addendum focuses on the president's message (February 18), which outlines a three-part program: for the employed population, a National Health Insurance Standards Act. mandating employer-provided insurance financed by joint employer-employee contributions, offering a standard basic benefit package subject to deductibles and copayments up to $5,000 of costs and full catastrophic coverage to $50,000; for the poor, a Family Health Insurance Plan (FHIP) basically federally financed at income levels below $3,000, with graduated consumer payments in the

$3,000-$5,000 income range. The FHIP will essentially replace Medicaid. Finally a revised Medicare system will integrate parts A and B with elimination of premiums and with some increase in copayments.

To improve delivery and effect the economies and efficiencies presumed to accrue through group practice, the president's plan encourages the development of HMO's (Health Maintenance Organizations) providing prepaid comprehensive services to a voluntarily enrolled population.

If viewed as an interim stage to a health security system, the Nixon plan has the virtue of stressing specific goals rather than embarking on a fundamental reform of the current health-care structure. Except for modest expansion of government responsibility for the low income population which will shift completely to the federal treasury, health care for the majority under 65 will continue to be financed and administered as it has been through a mixture of the Blues and commercial insurance. The initial proposals provides for setting national insurance standards and the president has indicated that he may later recommend further controls.

Recognizing the fact that extended hospital care is financially crippling to most families, the president has recommended liberal catastrophic coverage. While detailed data are still forthcoming it would appear, however, that families must cover about $1,700 of initial expenses before becoming eligible for catastrophic coverage. This leaves most wage-earning families vulnerable to excessive costs.

The FHIP, devised to be congruent with the proposed Family Assistance Plan, is on its face highly questionable because of its requirement for premium payments on a sliding scale for families having incomes between $3,000 and $5,000.

Finally, with respect to the widely publicized HMO's, the administration may succeed in stimulating the growth of a limited number of prepaid group-practice units concentrating on services to former Medicaid recipients and other low income families. To believe that HMO's will become the dominant or preferred form for rendering services to the broad middle class is clearly illusory.

Initial response to the president's proposal has been unenthusiastic. All of the plans to date give little or no assurance that the serious defects in the present health-care system will be substantially reduced or eliminated. What they do underscore is the probable expenditure of tens of billions of additional dollars. The Congress and the public still face the challenge of devising remedies for present shortcomings that hold reasonable promise of being successful without forcing the American consumer into spending an ever-higher proportion of his disposable income for medical services that will contribute little to raising his health status.